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FACT SHEET on RURAL HEALTH AND SANITATION 1/

Provision of better rural health facilities will be a major post-war task for rural communities of the United States. In addition to the obvious job of providing the physicians, dentists, nurses, and hospital and sanitation facilities so badly needed in some rural areas, there will be the important functions of general education in the use of health facilities and the working out of plans to bring these facilities to the many rural people who do not now have them.

The Signs of Bad Rural Health.-- Farm youth, 18 and 19 years old, showed the highest Selective Service rejection rate for physical, mental, or educational defects of any occupational group -- 41 percent compared to an average of 25 percent for other groups.

In 1900 rural death rates were 50 percent lower than urban. In 1940 rural death rates were only 10 percent lower than urban. So, while the health of the city people has been improving rapidly, progress in the rural areas has been relatively slow. Death rates from some preventable diseases tend to be higher in rural areas than in urban. Here are a few figures:

U. S. Census Bureau Mortality Summaries for 1940 -- Rates per 100,000

Disease	Urban	Rural
Infant mortality 1/	42.3	50.7
Maternal mortality 1/	3.4	4.0
Typhoid, paratyphoid fever	.6	1.6
Diphtheria	.6	1.5
Malaria	.3	1.8
Pellagra	.8	2.3
Pneumonia, influenza	63.4	76.6

1/ Rates per 1,000 live births

Also, rural people are probably ill oftener than city people. A report on the findings of the Committee on Costs of Medical Care from 1928-31 showed illnesses to be more frequent in rural communities under 5,000 than in larger communities of 100,000 or over.

A study of 12,000 Farm Security Administration borrowers in 17 States showed only 4 in every 100 persons in top-notch condition. Seven out of every ten persons over 5 years of age had decayed permanent teeth; 1 in every 12 children under 15 years of age was suffering from malnutrition; 1 in every 17 children had rickets or showed after-effects of rickets; 41 percent of all wives in white families had second or third degree injuries resulting from childbearing; more than 55 percent of all persons had defective tonsils; 1 out of every 12 heads of white families had a hernia.

1/ Prepared by Gustav Larson, Division of Economic Information, Bureau of Agricultural Economics, in cooperation with the Department's Interbureau Working Group on Health and Sanitation.

Rural People Have Less Doctor's Services.-- Although sickness and death from many diseases are more frequent in rural areas than in urban, the health facilities and services offered are considerably less. The survey made by the Committee on the Costs of Medical Care showed doctors' calls per year for each 1,000 of rural population to be 2,200 compared to 2,700 to 3,000 for urban areas. Thus the number of office and home calls made by physicians among the farm group is only about 70 percent of the number made among city people. Farm families also have fewer surgical operations (especially to correct chronic conditions) than city families. The surgical operation rate for rural people is only 48 per 1,000 as compared to 73 per 1,000 for city people.

The national physician-to-population ratio which is considered the minimum necessary to protect civilian health, is probably about 1 to 1,000. Individual areas are considered critical if they have a ratio of one physician to 1,500. In April, 1942, 16 rural States had less than one active private practitioner for 1,500 people in 1,005 rural counties which neither included a metropolitan center nor were adjacent to counties which had metropolitan centers. The total population of these counties exceeded 22,000,000. The average number of persons per active practitioner in these 1,005 counties was 2,015. In the same month, an equitable distribution of the Nation's available physicians could have provided one for every 937 persons.

But illustrations based on averages fail to reveal how bad the physician shortage is. Some States have many counties with ratios of one physician to every 2,500 or 3,000 people. And ratios of one physician to 5,000 or even 10,000 people occur in some rural districts.

The shortage of dentists in rural areas is even more acute. Among low income farmers, dental care is virtually unknown. One southern State reported 1 dentist to every 11,000 people in the entire State. Specialists likewise are practically unknown in rural areas. Neither do rural people often use specialist available in cities.

Rural Areas Have Inadequate Hospital Facilities.-- Many rural areas have inadequate or no hospital facilities. Approximately 1,200 counties with a 1940 population in excess of 15,000,000 persons had no recognized hospital facilities. While many of these counties have had some service from adjoining counties, many are in dire need of hospitals--at least emergency facilities. And it should not be assumed that all such counties would require hospitals. Properly organized outpost clinics which are affiliated with hospitals might provide adequate diagnostic facilities and serve a screening function for distant hospitals.

Neither do rural people get the hospital care that city people do. Rural people (per 1,000 population) spend about 500 days a year in hospitals against 700-900 for city people.

Rural Sanitation Facilities Are Bad.-- In 1940 about 5,294,000 rural homes needed new or improved water supplies; 5,100,000 rural homes needed new or improved sanitary privies. Included in these totals were 1,550,000 rural homes without a water supply within 50 feet and 850,000 homes without any toilet facilities.

In 1941, of America's 3,070 counties, 1,400 were without services of full-time departments of public health--and practically all of them were rural counties. The situation now is even worse because of the war.

Causes of Inadequate Rural Health Services.-- Many factors contribute to inadequate rural health and shortage of medical and sanitation facilities and doctor, dentist, and health and sanitation services. The most important factor is probably that rural people normally can't afford medical and hospital treatment and care. In 1939

nearly 3,000,000 fa[illegible]oduced under $600 worth of farm pr[illegible] With incomes like that people often s[illegible]way from doctors and hospitals until they are beyond help. Low incomes have mea[illegible] that rural areas could not support the necessary medical, hospital, and sanitatio[illegible] facilities. Then, too, in some areas the distances from doctors and hospitals prevents rural people from obtaining medical aid or hospitalization.

Another factor is the lack of understanding of disease and of the importance and place of preventive and curative medicine and surgery. Many rural people don't know that hookworm can spread if inadequate or no toilet facilities are available; they are unaware of the relationship of pellagra to poor nutrition, the importance of dental care and hospitalization when needed. Too many rural people still view the hospital as a place to "die in " and the physician as the man "to avoid."

What's Being Done Now About Rural Health: Farm Security Plans.--Some public and private organizations have recognized the need for better rural health facilities and services and have helped rural people to get them. The better known of such programs is that of the Farm Security Administration. The plans for FSA borrowers vary in many respects, but most of them have certain elements in common.

Essentially FSA plans are simple health insurance plans. Borrower families who wish to participate pay annual membership fees in advance. They work out agreements with physicians, dentists, and hospitals covering the services to be provided and the terms of payment from the pooled fund made up from membership fees. The family can choose any physician or dentist it wants from among those taking part in the plan.

Thus, FSA fosters voluntary cooperation between the "producers" of medical service and the "consumers" and has developed plans to fit local conditions. Participating farm families have learned to budget and pay for some of their sickness costs as groups rather than as individuals. FSA has advanced, in the form of loans, the money needed for regular prepayments, if the farmers' own resources were inadequate.

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On June 30, 1944 there were FSA health service plans operating in 1,012 counties of 39 States and Puerto Rico with a membership of 70,000 families, or 363,000 persons. Most of these plans provided physicians' care, and many of them provided surgical care, hospitalization, or dental care.

Attention has also been given to encouraging existing group hospitalization plans to include rural people at rates adjusted to their lower effective demand for hospital care. The Blue Cross Hospitalization plans have, accordingly, made special provision for FSA borrowers in some States.

The FSA also supervises the Department of Agriculture's "experimental" rural health program, under which there were established six county-wide experimental health associations open to all families earning most of their income from agriculture. Financial assistance is extended to the associations to enable low-income farm families to participate. With more than 5,800 families as members, this program renders a volume of health services far in excess of that received by rural people in general.

Another aid to rural health has been FSA's assistance to low-income farmers in improving sanitation facilities. About 100,000 farm families have been helped to get new sanitary privies, to improve their water supplies, or to screen their homes.

Health Program for Seasonal Farm Workers.--Another program designed to improve certain rural health conditions is the one conducted by War Food Administration's Office of Labor. It was started originally by FSA to help the tens of thousands of migrants in California and other points of seasonal farm labor concentration. During the war this program has provided medical and dental services not only for thousands of farm workers recruited and transported across State lines by the Government but also for about 100,000 farm workers brought into the United States from Mexico and the West Indies. This program is operated through six regional agricultural Workers Health Associations, nonprofit medical service corporations financed entirely by WFA rather than by contributions from the farm workers themselves.

Farmers' Union Hospi[illegible]sociation.--Perhaps the best known [illegible]health program for farm people, outside of FSA is the cooperative hospital at Elk[illegible], Oklahoma. This institution is owned and operated by the Farmers' Union Hospital [illegible]sociation for the benefit of its members. The physicians are on salary, and a family of four pays $25 a year, with $6 extra for each additional family member. Extra charges are made for home calls, surgical care, maternity service, and general hospitalization. The purchase of a $50 share in the co-op is required of all members.

Blue Cross Hospitalization Plans.--In a few areas efforts have been made to reach farm people by the Blue Cross Hospitalization plans. These are simply voluntary prepayment plans to pay for hospital services. The group pays membership fees to the Blue Cross plan and the plan pays the hospital when a member has to be admitted. One of the chief problems is developing convenient ways of making periodic collections of fees. In some instances banks make periodic deductions from the farmer's account. In some of the Midwestern States a few rural communities have been organized as a whole with the appointment of a local trustee or committee to be responsible for collection of funds. Groups such as farmers' cooperatives, Granges, rural churches, or other such institutions have also been considered as mechanisms for collection of membership fees.

Farm Bureau Health Plans.--Farm Bureaus in about 20 States have developed health plans for their members. Most of such plans are essentially sub-contracts with Blue Cross Associations. Others are cash indemnity plans, in which a member is awarded a cash benefit for illnesses, out of which he may pay for or purchase medical services. The benefits usually cover a period of illness only in excess of 7 days.

Philantropic Foundations.--Certain philantropic foundations have undertaken experiments in medical care services for rural people on a demonstration basis. Chief among these are the Commonwealth Fund, with its activities primarily devoted to the field of public health services and hospitalization; the Kellogg Foundation, with its activities devoted chiefly to public health services; and the Bingham Associates Fund, devoted primarily to the coordination of rural medical practice with specialist services in the urban centers. These demonstrations have done much to show what may be expected in the way of an improved quality of medical services for rural people when ample funds are available.

Public Health Activities.--General public health activities, promoted by the Federal Government, have exerted considerable positive effect on rural health services. Chief among these are the venereal disease control and the general public health activities, sponsored through grants-in-aid to the States from the United States Public Health Service, and the maternal and child health activities, promoted through grants-in-aid to the States from the Children's Bureau of the Department of Labor.

Voluntary Agencies.--Finally, the activities of numerous voluntary agencies have had their effect on the rural areas. Chief among these have been the programs of frontier nursing services, the National Tuberculosis Association, the American Social Hygiene Association, and the American Red Cross. Since the great bulk of funds for the support of these activities, however, must come from local voluntary contributions, and since rural per capita income is so low, the strength and the effect of these voluntary agencies has been rather limited in rural communities.

Plans for Solving The Problem.--This fact sheet presents some information on the present rural health situation and on what is being done now to meet it. It should be emphasized that relatively few rural people are now participating in or receiving the services mentioned. There is a big job to be done in the field of rural health. A work group of the Department of Agriculture's Interbureau Committee on Post-war Programs is now working on a report based on the recommendations of all States that will suggest what farmers can do to improve rural health services. The report is expected to be ready early in 1945.